Guidelines for Providing Services for Persons with Co-occurring Disorders participating in MHSA Adult/Older Adult/TAY Full Service Partnerships
A Crosswalk of the 1) MHSA Vision Statement & CSS Plan Requirements, the SAMSHA Resource Manual DACT Fidelity Items, AB 2034 Critical Elements, the SAMHSA Resource Manual, Integrated Dual Diagnosis Treatment Fidelity Items and the SAMHSA General Organization Index
February 28, 2007

Fidelity and Critical Element Items:	**MHSA Vision Statement & CSS Plan Requirements for Full Service Partnerships (FSP)**	**CSS System Development & Outreach & Engagement Strategies that Support FSPs**	**SAMHSA Resource Manual for ACT: Fidelity Items**	**AB 2034 Critical Elements**	**SAMHSA Resource Manual for IDDT: Fidelity Items (Rev. for CA.)*** **	**Recommended Guidelines for FSPs serving with co-occurring disorders**
Caseload	Caseload low enough to meet level of individual's need (CSS Plan Req., p. 22)		Client/provider ratio of 10:1 (H1)	Client/provider ratio of 10–15:1	Client/provider ratio of 20:1 or less (IDDT-CA 19*)	10 - 15
Team Approach		For dually diagnosed clients, integrated services are provided from one team with one service plan for one person (CSS Strategies, pg. 31)	90% of clients meet with more than one staff meeting within 2 week period (H2)	Each client has individual or team PSC		Use Team Approach
Personal Service Coordinators	Adults will have an identified PSC, who will serve as a single point of responsibility PSCs must be culturally competent and know community resources of the client's racial ethnic community.			Each client has individual or team PSC		Each client has an individual or team PSC

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Program/Team Meeting/Supervision			Team meets 4 x/week & reviews each client (H3)	Daily team meetings	Team meetings daily (IDDT-CA 4) 80% of staff receive structured weekly supervision, focusing on specific clients and application of IDDT Model (G8)	
Practicing Team Leader			Team leader provides services 50% of the time (H4)		Team leader at least 10% time and responsible for training, referrals, monitoring, improve quality of IDDT implementation, empowered and accountable to senior mgmt, and carry caseload (G14)	
Continuity of Staffing			Less than 20% staff turnover in 2 years (H5)			
Staff Capacity			95% or more staffing. At least 10 FTEs (H6 & 11)			

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Multidisciplinary Staffing		Integrated assessment teams that provide comprehensive mental health, social, physical health and substance abuse and trauma assessments p.32	At least 1 psychiatrist:100 clients; 2 nurses:100 clients; voc spec w/1 year VR training or supervised experience (2 Voc spec:100 clients) (H7-8; H10)	AB 2034 Service teams ideally include a diverse group of personal service coordinators reflective of the client population, and specialists in housing, employment and substance abuse, as well as nurses and psychiatrists.	Team includes Case managers, psychiatrist, nurses, residential staff, voc specialists and multiple DD specialists w/2 years experience; housing specialist (IDDT-CA 4 & 8)	Team includes personal service coordinators, multiple DD specialists w/2 years + experience, nurses, specialists in housing and employment.
Cultural Competence	Service providers understand and utilize the strengths of culture in service delivery. PCs must be culturally competent and know the resources of the client's racial ethnic community (CSS plan Req., pp 5 & 22)	Strategies include reducing ethnic disparities. (CSS Funding Req., pg. 8) integrated services with ethnic specific community-based organizations CSS p. 32; community cultural practices CSS p. 32 Ethnic specific outreach strategies				Culturally Competent
Training				Training & Technical Assistance	80% of practitioners receive standardized training annually (G7)	Regular annual training

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Practice Integrated into daily work		Values-driven culturally competent evidence-based or promising clinical services that are integrated with overall service planning…p.33			All staff participate in IDDT skills training, prepare for IDDT sessions, document IDDT sessions, attend IDDT weekly supervision, attend client-centered tx team meetings or consult with other tx providers (G13)	All staff participate in training and regular ongoing supervision in Dual Diagnosis treatment
Integrated Substance Abuse/Dual Diagnosis Specialists	For each FSP the county agrees to work with the individual and his/her family to provide all necessary and desired appropriate services and supports…CSS p.22	For Dually Diagnosed clients integrated services are provided from one team with one service plan for one person (CSS Strategies, pg. 31)	2 SA Specialists w/1 year SA training or supervised experience (2 SA spec:100 clients) (H9)	As possible include dual diagnosis or substance abuse specialist on the team	Multiple DD specialists w/2 yrs exp, fully integrated into team (IDDT-CA 5)	Multiple DD specialists with 2+ years of experience

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Admission Criteria	In selecting initial populations attention should be paid to populations and individuals that are currently unserved, and to reducing racial/ethnic disparities (CSS Plan Req.,7) Priorities for TAY, Adult, Transition age older adults and older adults are found on pp 21 & 22 of CSS Plan Req.)	Identified full service populations and for other clients consistent with the populations described on pp. 21&22	Program recruits defined population and complies with criteria (O1)	TAY, Adults, Older Adults who are homeless or at risk of being homeless.	80% of clients receive standardized screening and agency tracks eligibility for DD services (G2)	
Intake Rate			No more than 6 intakes per month O2)			
Integrated services	Integrated service experience for individuals, including people with co-occurring disorders (SA, physical health); services are seamless; delivered or coordinated thru single agency or system of care.	Integrated assessment teams that provide comprehensive mental health, social cultural, physical health, substance abuse and trauma assessments…p.32 Integrated service agencies that provide and/or broker all services client needs. (CSS Plan Req., p. 31)	Team is responsible for all services: CM, psychiatric services, housing support, SA tx and Employment services(O3)	Services are provided by service team or by other providers in close collaboration with service team	One person, one plan and one team to provide integrated substance abuse and mental health services	One person, one plan and one team to provide integrated substance abuse and mental health services

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Integrated Services, Cont.	Services are integrated with ethnic-specific community-based organizations. (CSS Plan purpose & Summary)	Integrated physical and mental health services…p.34 Integrated services with law enforcement, probation and courts.p.31… Intensive community services and support teams capable of providing services to clients where they live, 24/7 (CSS Plan Req., p. 31				
24-hour service availability	PSC/team, known to the family, has 24/7 availability to respond to individual, family, landlords and law enforcement		Program provides 24 hour crisis coverage. (O4)	PSC/team has 24/7 availability to respond to individual, significant others , landlords, law enforcement, others		PSC/team has 24/7 availability to respond to individual, significant others , landlords, law enforcement, others
Hospital admissions & discharge planning	The integrated service experience centers on addressing needs using the full range of community-based treatment in order to avoid frequent emergency medical care or hospitalization. (CSS Req., pg 6)		Team involved in 95% of hosp admissions & discharges (O5&6)			

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Time Unlimited Services	"Whatever it takes" philosophy: as long as person needs services		Fewer than 5% are expected to graduate each year. 95% of caseload is retained over a 12-mo period (O7 & S2)	No time limits	No time limits, services available at any time, no waiting lists (IDDT-CA 9)	No time limits
Community-based Services	Services include linkage to or provision of all needed services or benefits as defined by client or family in consultation with the PSC/case manager. (CSS Plan Req., p. 22)	On site and/or integrated services with primary care, faith based providers, ethnic specific community-based organizations, client run programs; Crisis Residential Tx Respite housing, in-home respite CSS p. 32-33	80% of face-to-face contacts are in community (S1)	Services provided in the field (not in the clinic or office)	Related services identified in tx pl and accessed in 2 mos. Full range of wet, damp and dry housing; residential program affiliated with program (IDDT-CA 7 & 8)	Ready access to housing and other community resources
Housing	Services include linkage to or provision of all needed services or benefits as defined by client or family in consultation with the PSC/case manager. (CSS Plan Req., p. 22)	Supportive Housing: affordable, permanent housing with support services available. (CSS Plan Req., p. 31) Other housing options, including temporary & transitional housing, safe havens.		Housing First Supportive Housing	Assures access to housing	

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Supported Employment/ Supported Education	Services include linkage to or provision of all needed services or benefits as defined by client or family in consultation with the PSC/case manager. (CSS Plan Req., p. 22)	Supportive Employment; Vocational services; supportive education CSS Plan Req., pp. 32, 33)		Work First Supportive Employment	Assures access to employment and education services	
Collaborations	Individualized service and supports plan must reflect community collaboration p. 22	Community collaboration brings community members together in a supportive atmosphere to solve problems (CSS Plan Req., p. 4) Collaborations with primary care and law enforcement, faith-based providers (CSS Plan Req., p. 31, 32)		Collaborations (with housing, employment, health and public safety organizations/associations)		Program coordinates with other agencies and community resources
Assertive Engagement	Personal Services Coordinators responsible for engaging person in need or using services Services are voluntary, no coercive in nature	Outreach services to unserved persons, including homeless and ethnic groups and have the ability to provide for immediate needs of health, food, clothing and shelter. (CSS Plan Req., p. 32)	Program demonstrates strategies for street outreach and legal mechanisms probation/parole/OP commitment**) whenever appropriate (S3)	Field Based outreach and services Relationship between provider & recipient – the working alliance	Policy, supervision & charting requirements encourage in situ and engagement outreach, are reflected the charts (IDDT-CA 10)	Program demonstrates strategies and policies for in situ and engagement outreach

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Flexible funding	Flexible funding to meet goals of individual service and support plans			Funds are used to provide basic needs, wrap around services, e.g., housing and housing subsidies, food, transportation and "just in time" tools for engagement ("burger bucks")		Funds are used to provide basic needs, wrap around services, e.g., housing and housing subsidies, food, transportation and "just in time" tools for engagement
Intensity/Frequency of Service and Contact	Caseload low enough to meet level of individual's need (CSS Plan Req., p. 22)		2 hours and 4 face-to-fact contacts/week with client (S4 & S5) 4 or more contacts/mo with personal support system in the community (S6)	Individually determined		Regular ongoing support as needed to support person's service plan (from 7 days a week to once a month)
Work with informal support system	Plans must operationalize the five fundamental MHSA concepts of community collaboration, cultural competence, client/family driven experiences (including increased choice of services), wellness focus & integrated service (CSS Plan Req. pp. 7 & 22)	Family support, education and consultation services… Peer support servicesp.33			Program implements an explicit evidence based family intervention for DD (IDDT-CA 14)	Program works with families as part of the service team when requested by client

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Integrated SA/MH Assessment of Clients with Dual Diagnosis	Integrated Assessment teams that provide comprehensive MH, social, physical health, SA and trauma assessments, strengths based, focused on client engagement and provide gender and cultural specific assessments as in the DSM-IV-R formulation	Integrated assessment teams (CSS Plan Req., p. 32)			Assessment of mental illness & substance abuse with case formulation developed based on relationship between the two (IDDT-CA 1) 80% of clients receive assessments at least annually (G4)	Integrated assessment
Integrated SA/MH Crisis Plan					80% of the clients have a crisis plan and 75% of plans target both SA & MI (IDDT-CA 2)	Integrated Crisis Plan
Individualized/ integrated SA/MH treatment plan	Individualized client/family-driven mental health services and supports plans that are person-centered and reflect the five fundamental MHSA concepts (CSS Plan Req. pp. 7 & 22)				100% of plans have case formulation based on comprehensive assessment. (IDDT-CA 3) 80% of clients have explicit plan related to IDDT	Integrated Service Plan
Client-directed care plans		Self-care plans (e.g., WRAP) CSS p.31 and 32				Promote Self-Care Plans

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Individualized SA TX Maybe use Motivational Interviewing in the title to use, as this is more common? Or is this mixed with other SA services?	Harm reduction (? Need to check)	Client with co-occurring disorders receives mental health and substance abuse services simultaneously, not sequentially from one team with one service plan (CSS Plan Req., p. 31)	Clients with SA spend 24 min/wk in formal SA Tx (S7)	Use of motivational interviewing Utilize harm reduction strategies	80% of client charts reflect motivational interviewing approach. Multiple staff trainings on MI annually. MI/SA counseling available in all aspects of programming (IDDT-CA 11 & 12)	Use of Motivational Interviewing
Dual Disorder Tx groups			50% or more of clients with SA attend 1 SA group meeting/mo (S8)		65% or more of clients attend DD group. Integrated groups where both disorders are focus of tx. (IDDT-CA 13)	Provide DD groups
Dual Diagnosis Model	Integrated treatment for persons w/DD, thru a single individualized plan, integrated screening & assessment at all point of entry into the service system (CSS Vision)	For Dually Diagnosed clients integrated services are provided from one team with one service plan for one person (CSS Strategies, pg. 31)	Program fully based in DD tx: stage-wise tx, non confrontational, considers interactions of MI and SA & has gradual expectation of abstinence. (S9)	Use of harm reduction, integrated MH/SA services	Stage-wise Tx - Full-range of interventions for all four stages of tx (IDDT-CA 6)	Provide stage-wise treatment
Participation in self-help groups	Peer support services are made available (CSS Funding Req., page 8)	Self help and client-run programs such as drop-in centers, club houses…CSS p.328)			65% of clients in active tx or relapse prevention stages attend self-help groups in the community. Staff proactively assist clients in utilizing self-help programs (IDDT-CA 15)	Support participation in community self help groups

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Hiring Consumers		Hire skilled consumers as team members	Consumers employed full-time as service providers with full professional status (S10)	Hire consumers as team members		
Pharmacological Tx	Provide education for consumers regarding use of medications		One psychiatrist /100 clients (H7)		Psychiatrist on multidisciplinary team; uses evidence base for prescribing psychiatric medications (IDDT-CA 4 & 16) Psychiatric medications are not withheld because person is using substances	Psychiatrist on multidisciplinary team; uses evidence base for prescribing psychiatric medications Psychiatric medications are not withheld because person is using substances
Interventions to promote health and reduce negative consequences of SA		The integrated service experience includes attention to, and including chronic health conditions. (CSS Req., pg. 6)	Program has gradual expectation of abstinence. (S9)	Use of Harm Reduction	Supports reduction of negative consequences of DD & interventions for trauma, smoking cessation, etc. (IDDT-CA 17)	Use of Harm Reduction
Secondary interventions for non-responders					Program identifies five or more interventions and has a formal way of identifying clients that need different interventions. Interventions are specified in charts of non-responders (IDDT-CA 18)	Program identifies interventions and has a formal way of identifying clients that need different interventions.

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Outcome Monitoring	DMH will develop standardized real time outcome/performance measurement requirements.			Clear objectives and real time client outcome data. Use in staff individual and group supervision	Standardized outcome monitoring occurs quarterly & results are shared with EBP practitioners, management and advisory committees(G10)	Clear objectives and real time client outcome data. Use in staff individual and group supervision on a regularly scheduled basis
Program Philosophy	Wellness focus, including the concepts of recovery and resilience "Whatever it takes"			The Whatever It Takes philosophy promoted through regional meetings of AB 2034 coordinators	Clear program philosophy understood by program leader and senior staff, practitioners providing IDDT, clients and/or family members receiving IDDT and clearly described in written materials (G1)	Program philosophy incorporates "whatever it takes" and is clearly understood and articulated by leaders, staff, clients, family members and in written materials

*Not included in the SAMHSA IDDT Fidelity Scale and not calculated in the scoring of the IDDT-CA scale.
** Involuntary programs not allowable under MHSA
***The CA IDDT precept modified the fidelity scale with the permission of SAMHSA